



WHATCOM COUNSELING & PSYCHIATRIC CLINIC

3645 E. McLeod Rd. Bellingham, WA 98226

Voice/TTY: (360) 676-2220 • Toll Free (888) 311-0120 • Fax: 676-7750

APPLICATION FOR EMPLOYMENT, VOLUNTEERS & INTERNS

Whatcom Counseling and Psychiatric Clinic is committed to enhancing the diversity of our staff. We strongly encourage applicants to apply without regard to race, color, national origin, gender, age, religion, creed, marital status, ancestral heritage, sexual orientation, Vietnam Era Veteran status, or the presences on any physical, mental and or/sensory disability. This includes persons who have HIV/AIDS. If accommodations are needed for participating in the application or interview process, please let the receptionist or Human Resources know.

DIRECTIONS: *Please print or type. All sections of application must be completed in full before consideration. Attach personal resume to this completed application form if desired.*

POSITION(S)

APPLIED FOR: 1. _____

2. _____

Full Time Part Time Temporary On-Call

Date Available for Work? _____

PERSONAL DATA			Date of Application:	
Name	Last	First	Middle	
Street Address				
City			State	Zip Code
Home Telephone	Work Telephone	Cell/Pager Number	May we contact you at work?	
			Yes	No

EDUCATION					
Name of School/College/University	City, State	Course of Study	Years Completed	Did you graduate?	Degree or Diploma
Graduate				Yes No	
College				Yes No	
Business/Trade/Technical				Yes No	
High School/GED				Yes No	
Other School				Yes No	

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EMPLOYMENT RECORD			
<i>Please list your employment history beginning with your most recent position. Do not reference personal resume. Use extra pages if necessary. Please feel free to attach your resume but complete all sections below.</i>			
Employer			Supervisor:
Street Address			Supervisor's Telephone
City	State	Zip Code	May we contact? Yes No <i>We may contact if left blank</i>
Salary/Hourly Rate: Start \$		Final \$	Hours Worked per Week
Position title and duties:			
Reason for Leaving			Dates Employed (Mo/Yr) From ___/___ To ___/___

Employer			Supervisor:
Street Address			Supervisor's Telephone ()
City	State	Zip Code	May we contact? Yes No <i>We may contact if left blank</i>
Salary/Hourly Rate: Start \$		Final \$	Hours Worked per Week
Position title and duties:			
Reason for Leaving			Dates Employed (Mo/Yr) From ___/___ To ___/___

Employer			Supervisor:
Street Address			Supervisor's Telephone ()
City	State	Zip Code	May we contact? Yes No <i>We may contact if left blank</i>
Salary/Hourly Rate: Start \$		Final \$	Hours Worked per Week
Position title and duties:			
Reason for Leaving			Dates Employed (Mo/Yr) From ___/___ To ___/___

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Employer			Supervisor:
Street Address			Supervisor's Telephone
City	State	Zip Code	May we contact? Yes No <i>We may contact if left blank</i>
Salary/Hourly Rate: Start \$		Final \$	Hours Worked per Week
Position title and duties:			
Reason for Leaving			Dates Employed (Mo/Yr) From ___ / ___ To ___ / ___

REFERENCES		
Please list three professional references		
Name	Title	
Relationship to applicant	Years Known	Telephone
Address		
City	State	Zip Code

Name	Title	
Relationship to applicant	Years Known	Telephone
Address		
City	State	Zip Code

Name	Title	
Relationship to applicant	Years Known	Telephone ()
Address		
City	State	Zip Code

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LICENSES - Please indicate all current licenses:

- WA State Counselor Certification (Type: _____)
- Psychologist (PHD) Licensed Practical Nurse
- Psychiatrist (MD/DO) Drivers License
- Registered Nurse

Please list any other licenses or profession certificate you have that are required or applicable to the position:

SPECIALISTS - Please indicate if you meet WAC qualifications for the following:

- Qualified Chemical Dependency Counselor Mental Health Professional
- Child Mental Health Specialist Geriatric Mental Health Specialist
- Disabilities Mental Health Specialist (Specify: _____) Sexual Minority Specialist
- Ethnic Minority Mental Health Specialist (Specify: _____)

Please list any other areas of specialty of which you are qualified:

*Documentation will be required from previous supervisor(s) identifying his/her credentials, your full/part time status, your specific dates of employment, and the number of training hours with subjects you have received in the area of specialty.

SUPPORT/ADMINISTRATIVE SKILLS

Typing Speed: _____ WPM	Dictaphone: Yes	No	Data Entry: Yes	No
Word Processing: Yes No	Ten Key: Yes	No	Fax Machine: Yes	No
	Database: Yes	No	Spreadsheet: Yes	No

Computer Skills:

Hardware Knowledge:

Software Knowledge:

Maintenance Skills:

Other Relevant Skills:

DISCLOSURE STATEMENT
ANSWER YES OR NO AND SPECIFY WHERE INDICATED

PRACTICE INFORMATION:

Has your membership in any professional organization ever been denied, investigated, revoked or suspended, or is any such action pending?

Yes _____ No _____

Has a renewal of any of your professional membership ever been denied?

Yes _____ No _____

Have you been subject to any disciplinary proceedings by any professional association or organization, or is any such action pending?

Yes _____ No _____

If your answer to any of the above is yes, please explain: *Use extra pages if necessary*

Have you ever been denied hospital or clinical privileges or the renewal of such, at any health care facility, clinic or hospital, or is any such action pending?

Yes _____ No _____

If yes, please explain:

CURRENT MALPRACTICE LIABILITY INSURANCE DATA: Indicate name and address of your insurance carrier and policy number. If none, so state.

Expiration Date: _____ Amount of Coverage: _____

Have any malpractice allegations involving your work ever been settled by you or your carrier prior to the filing or the entry of a judgment of either a claim or a lawsuit?

Yes _____ No _____

If your answer to the above is yes, please explain each claim or allegation, the circumstances, including relevant dates, and how it was disposed. *Use extra pages if necessary*

CRIMINAL CONDUCT: Conviction of a crime will not necessarily be a bar to employment. Factors such as age at the time of offense, remoteness of the offense in time, and rehabilitation will be taken into account in determining the effect of the suitability for employment.

In the last ten years have you ever been convicted of, or pleaded guilty to, a criminal offense, other than a minor traffic violation?

Yes _____ No _____

If your answer is yes, explain the nature of the charge(s), relevant date(s), location(s), and how the matter(s) was disposed. *Please see next page.*

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DISCLOSURE STATEMENT

I, _____, (Print name), swear under penalty of perjury that I have responded truthfully to

all of the statements below.

The following questions are asked consistent with the requirements of RCW 26.44.020, 43.43.830, 13.34.040, Title 26 and Chapter 74.34

I. CRIMES AGAINST PERSON AND CRIMES RELATING TO FINANCIAL EXPLOITATION Have you ever been convicted of any of the following crimes? ___ YES ___ NO If YES, please check all that apply and Provide detailed information in Section VI.		
___ Arson (1st Degree) ___ Assault (Custodial) ___ Assault (Simple or 4th Degree) ___ Assault (1st, 2nd, 3rd Degree) ___ Assault of a Child (1st, 2nd, 3rd Degree) ___ Burglary (1st Degree) ___ Child Abandonment ___ Child Abuse or Neglect (RCW 26.44.020) ___ Child Buying or Selling ___ Child Molestation (1st, 2nd, 3rd Degree) ___ Communication with a Minor ___ Criminal Abandonment ___ Criminal Mistreatment (1st, 2nd Degree)	___ Custodial Interference (1st, 2nd Degree) ___ Extortion (1st, 2nd, 3rd Degree) ___ Forgery ___ Incest ___ Indecent Exposure (Felony) ___ Indecent Liberties ___ Kidnapping (1st, 2nd Degree) ___ Malicious Harassment ___ Manslaughter (1st, 2nd Degree) ___ Murder (Aggravated) ___ Murder (1st, 2nd Degree) ___ Patronizing a Juvenile Prostitute ___ Promoting Pornography	___ Promoting Prostitution (1st Degree) ___ Prostitution ___ Rape (1st, 2nd, 3rd Degree) ___ Rape of Child (1st, 2nd Degree) ___ Robbery (1st, 2nd Degree) ___ Selling/Distribution Erotic Material to a Minor ___ Sexual Exploitation of a Minor ___ Sexual Misconduct with a Minor ___ Theft (1st, 2nd, 3rd Degree) ___ Unlawful Imprisonment ___ Vehicular Homicide ___ Violation of Child Abuse Restraining Order ___ Or Any of These Crimes That May Have Been Renamed
II. CONVICTING BY COURT Have you ever been convicted by a court of a crime relating to financial exploitation if the victim was a vulnerable adult, or a crime against a child or other persons? ___ YES ___ NO If YES, please provide detailed information in Section VI.		
III. RELATED PROCEEDINGS Have you ever been found in a dependency action, domestic relations proceeding, disciplinary board hearing, or protection proceeding to have; sexually assaulted OR exploited, sexually or physically abused, a minor or developmentally disabled person OR to have financially exploited or abused a vulnerable adult? ___ YES ___ NO If YES, please provide detailed information in Section VI.		
IV. DRUG-RELATED CRIMES Have you ever been convicted of a crime related to the manufacture of, delivery, or possession with intent to manufacture or deliver a controlled substance? ___ YES ___ NO If YES, please provide detailed information in Section VI.		
V. MEDICARE FRAUD-RELATED CRIMES Have you been debarred, excluded or otherwise ineligible for participation in federal health care programs? ___ YES ___ NO If YES, please provide detailed information in Section VI.		
VI. COMMENTS: 		
I understand a background investigation regarding the above stated inquires will be made. The Washington State Patrol Criminal Identification System will be contacted in this regard and fingerprinting may be required. I also understand the results of this investigation will be used only for the purpose of making an initial employment or engagement decision. Any offer of employment is conditional pending the completion of the background investigation and contingent upon the investigative findings. Whatcom Counseling & Psychiatric Clinic shall determine in its sole discretion whether such findings preclude employment.		
_____ Signature of Applicant	_____ Date	

**SUPPLEMENTAL
ANSWER YES or NO & SPECIFY WHERE INDICATED**

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Are you legally authorized to be employed in the United States?

Documentation is required for the I-9 form

Yes ____ No ____

Can you work unusual hours (i.e. overtime, weekends or evening shifts)?

Yes ____ No ____

Can you travel within the area if your position requires it?

Yes ____ No ____

Do you have proof of auto insurance?

Yes ____ No ____

Do you have current documentation of CPR training?

Yes ____ No ____

If you are under the age of 18, can you furnish a work permit?

Yes ____ No ____

Do you have a Food Handler's Permit?

Yes ____ No ____

Do you have a private practice?

Yes ____ No ____

Type _____

Have you ever been employed by this agency in the past?

Yes ____ No ____

Are any accommodations requested to facilitate your participation in the application or interview process?

Yes ____ No ____

If Yes, please explain:

Are there any reasons that will prevent or limit you from satisfactorily performing the job(s) for which you are applying?

Yes ____ No ____

If Yes, please explain:

Are you able to perform the essential function of the job with or without reasonable accommodations?

Yes ____ No ____

For research purpose, how did you learn about this posting opening?

____ WCPC Posting

____ WCPC Employee

____ Newspaper Ad

____ Posting at other agency

____ Internet

____ Other

NOTIFICATION:

Submitting a resume/application indicates your interest. You become an applicant when the resume/application is matched successfully with a position and an interview is requested. We will then contact you if you are selected for an interview.

**CAREFULLY READ THE FOLLOWING STATEMENTS AND AGREEMENT BEFORE
SIGNING THIS APPLICATION**

I agree that my previous employers may release all information regarding my employment history and I hereby release my previous employers and the Clinic from all claims and liabilities arising from the release of such information.

I authorize investigation of all statements contained in this application for employment as may be necessary in arriving at an employment decision.

I understand that I will have to undergo a criminal background check to receive clearance for employment.

I **certify** that this application and any other submitted materials contain no willful misrepresentation or falsifications, and that the information given by me is true and complete to the best of my knowledge and belief. I am aware that should investigation at any time disclose any misrepresentation or falsification, I may be summarily terminated or disqualified from holding any position at the clinic. This application becomes part of my permanent record if hired.

This application for employment shall be considered active for a period of time not to exceed 45 days. Any applicant wishing to be considered for employment beyond this time period should inquire as to whether or not applications are being accepted at this time.

Only U.S. citizens and others lawfully authorized to work in the United States will be hired.

The contents of this application do not constitute an express or implied contract of employment.

In the event of employment, I understand that I am required to abide by all policies, rules and regulations of the Clinic.

SIGNATURE OF APPLICANT

DATE

PRINT NAME

SOCIAL SECURITY NUMBER

**Whatcom Counseling & Psychiatric Clinic
Equal Employment Opportunity
Applicant Data Record**

As an Equal Opportunity employer, we are committed to an Affirmative Action Program which ensures equal employment opportunities regardless of race, color, national origin, sex, age, religion, creed, marital status, ancestral heritage, sexual orientation, Vietnam Era Veteran status, HIV/AIDS status or the presence of any physical, mental and /or sensory disability. The agency's employment practices are consistent with applicable federal, state and local regulations on non-discrimination and employment.

The purpose of this Data Record is to comply with government record keeping reporting and other legal requirements. Periodic reports are made to the government on the following information. The completion of this Data Record is **OPTIONAL**: if you choose to volunteer the requested information, please note that all Data Records are kept in a Confidential File and are **NOT** a part of your Application for Employment or personnel file.

PLEASE NOTE: YOUR COOPERATION IS VOLUNTARY. INCLUSIONS OR EXCLUSION OF ANY DATA WIL NOT AFFECT ANY EMPLOYEMNT DECISIONS. ALL AFFIRMATIVE ACTION INFORMATION IS CONFIDENTIAL.

VOLUNTARY SURVEY

(please print)

NAME: _____

POSITION APPLIED FOR: _____

DATE: _____

ETHNICITY

- Black
- Native American/Alaskan Native
- Hispanic
- Asian/Pacific Islander
- White
- Other

SEX:

Male Female

VIETNAM ERA VETERAN:

Yes No

DISABLED VETERAN:

Yes No

DISABILITY STATUS (*Check as appropriate*):

- Physical Disability
- Mental Disability
- Sensory Disability

DATE OF BIRTH: _____



ADDITIONAL CLINIC PROCEDURES FOR ASSURING CONFIDENTIALITY

As an employee, student, volunteer, or acting in any other capacity in connection with the WHATCOM COUNSELING & PSYCHIATRIC CLINIC, I agree to the following.

- 1. Charts will not be removed from the clinic without prior authorization from the Executive Director or designee.**
- 2. All charts, notes, and other written material concerning clients will be returned to the secured file room by the end of the day.**
- 3. Discussions regarding clinic clients will be held in staff offices or other places which assure privacy.**
- 4. Access to client files will be limited to Clinic professional and support staff, and volunteers (as recommended by their supervisors), and students supervised by clinic professional staff. Access to client files by anyone else must be approved by the Executive Director or designee.**
- 5. Charts and other confidential materials will be read for professional purposes only.**

I agree to comply with all of the above.

Signature

Date

Original to Personnel File



Client Rights

The Whatcom Counseling & Psychiatric Clinic keeps a record of the health care services provided to clients. We will not disclose client information to others unless we are directed to do so by the client or unless the law authorizes or compels us to do so.

A voluntary recipient of mental health services at Whatcom Counseling & Psychiatric Clinic has the following rights: (WAC 388-865-0410)

1. To be treated with respect, dignity, and privacy;
2. To develop a plan of care and services which meets your unique needs;
3. To receive the services of a certified language or sign language interpreter and written materials and alternate format to accommodate disability consistent with Title VI of the Civil Rights Act;
4. To refuse any proposed treatment, consistent with the requirements in the Involuntary Treatment Acts, chapters 71.05 and 71.34 RCW;
5. To receive care which does not discriminate against you, and is sensitive to your gender, race, national origin, language, age, disability, and sexual orientation;
6. To be free of any sexual exploitation or harassment;
7. To review your clinical record and be given an opportunity to make amendments or corrections;
8. To receive an explanation of all medications prescribed, including expected effect and possible side effects;
9. To have all information and records compiled, obtained, or maintained in the course of receiving services kept confidential as described in RCW 70.02, 71.05, and 71.34. We will not disclose your record to others unless you direct us to do so by informed written consent or unless the law compels us to do so.
10. To make an advanced directive, stating your choices and preferences regarding your physical and mental health treatment if you are unable to make informed decisions;
11. To receive direct access to mental health specialists for beneficiaries with long-term or chronic care needs (e.g., severely and persistently mentally ill adults or severely emotionally disturbed children);
12. If you are Medicaid eligible, to receive all services, which are medically necessary to meet your care needs. In the event that there is a disagreement, you have the right to a second opinion from a provider within the North Sound Regional Support Network (NSRSN) about what services are medically necessary. You have the right to a second opinion:
 - When you need more information about the medical necessity of the treatment recommended by the APN provider, and
 - If you believe the APN primary care provider is not authorizing medically necessary community mental health rehabilitation services.
13. To lodge a complaint with the Ombuds, NSRSN, or provider, if you believe your rights have been violated. If you lodge a complaint or grievance, you must be free of any act of retaliation. The Ombuds may, at your request, assist you in filing a grievance. The Ombuds' phone number is:
1-888-336-6164.

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14. Clients, parents or clients under the age of thirteen, and guardians of clients of all ages have the right to select a primary care provider from the available primary care provider staff within the APN Network;

15. To change primary care providers in the first ninety days of enrollment and once during a twelve-month period for any reason;

16. To file an administrative hearing with DSHS without first accessing APN's grievance process, and to use the DSHS rehearing and administrative hearing processes as described in chapter 388-02 WAC.

17. To appeal any denial, termination, suspension, or reduction of services and to continue to receive services at least until your appeal is heard by a fair hearing judge;

NOTE: All research concerning consumers whose cost of care is publicly funded shall be done in accordance with all applicable laws, including DSHS rules on the protection of human research subjects as specified in chapters 388-04 WAC.

Additional rights for clients on a Less Restrictive Alternative – You have the right¹

1. To receive adequate care and individualized treatment;

2. To make an informed decision regarding the use of antipsychotic medication and to refuse medication beginning twenty-four hours before any court proceeding that the clients has the right to attend.

3. To maintain the right to be presumed competent and not lose any civil rights as a consequence of receiving evaluation and treatment for a mental disorder;

4. Of access to attorneys, courts, and other legal redress;

5. To have all information and record compiled, obtained, or maintained in the course of treatment kept confidential as defined in chapter 71.05 and 71.34 RCW;

6. If the client is on a less restrictive alternative court order, to have access to attorneys, courts, and other legal redress;

7. To be told statements the client makes may be used in the involuntary proceedings.

NOTE: Any person who leaves a public or private agency following evaluation or treatment for mental disorder shall be given a written statement setting forth the substance of Section 450 RCW, 71.05 RCW and 3858-856-565 WAC.

I, _____, have read and understand the above client rights. I agree to comply with the Consumer Rights of Whatcom Counseling and Psychiatric Clinic

Signature

Date

¹ APN consent for Treatment/Client Rights rev 2/25/05, 07/12/02 services

Used to document consumer consent for voluntary

REQUEST FOR CONVICTION CRIMINAL HISTORY RECORD (RCW 10.97)

Any offer of employment is conditional pending the completion of the background investigation and contingent upon the investigative findings. Whatcom Counseling & Psychiatric Clinic shall determine in its sole discretion whether such findings preclude employment. Please fill out the following table, with the necessary information.

Subject Information: (Please type or print clearly)			Position: _____
			Volunteer: YES NO
Applicants Name: _____	_____	_____	_____
	Last	First	Middle
Alias/Maiden Name: _____			
Date of Birth: _____	Sex: _____	Race: _____	
	Month/Day/Year		
Drivers Lic. Number/State _____ / _____			

Practice Information (Extra space if needed)